

# IMPAIRMENT QUESTIONNAIRE

(RELEVANT PHYSICAL/MEDICAL CONDITIONS)

CLIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**Do you have any advance directives, a living will, or a durable power of attorney for health care decisions in place that ELC should be aware of?**

Yes  No

If yes, please give that information to the Intake Coordinator for placement in your clinical file.

\* Information on Advance Directives is available from the Intake Coordinator

Please check the current physical/medical conditions that apply to you today.

\_\_\_ **Not Applicable**

\_\_\_ Developmental Disability.

\_\_\_ Organically based problem in expressive communication

\_\_\_ Blindness or severe visual impairment

\_\_\_ Deafness or severe hearing loss

\_\_\_ Non-ambulation or major difficulties in ambulation

\_\_\_ Fibromyalgia

\_\_\_ Mental retardation

\_\_\_ Diabetes

\_\_\_ High blood pressure

\_\_\_ Immune system suppression

\_\_\_ Chronic pain

\_\_\_ Hepatitis

\_\_\_ M.S.

\_\_\_ Heart Problems

\_\_\_ Thyroid Problems

\_\_\_ Emphysema

\_\_\_ Cancer

\_\_\_ Polio

\_\_\_ Parkinson's Disease

\_\_\_ Tuberculosis

\_\_\_ Cirrhosis

\_\_\_ Alzheimer's Disease

\_\_\_ Korsakoff's Syndrome

\_\_\_ Stroke

\_\_\_ Leukemia

\_\_\_ Other Chronic health condition  
requiring on-going care (Please List)

\_\_\_ Seizure Disorder

\_\_\_ Blood Clots

\_\_\_ Arthritis

\_\_\_ Asthma

\_\_\_ Pregnancy

\_\_\_ Irritable Bowel Syndrome

\_\_\_ Diarrhea

\_\_\_ Eating Disorders

\_\_\_ Underweight

\_\_\_ Menopause

\_\_\_ Crohn's Disease

\_\_\_ Urinary Tract Infection

\_\_\_ Sleep Disorder

\_\_\_ Overweight

\_\_\_ Anemia

\_\_\_ Constipation

\_\_\_ Head Injury

\_\_\_ Allergies

\_\_\_ Ulcers

## Health Issues Questions:

Health Risks?  Yes  No  Decline to Report

Chronic Illness?  Yes  No  Decline to Report

Visit/check-up with PCP in the past 12 months?  Yes  No  Decline to Report

Regular preventative health screens?  Yes  No  Decline to Report